GROUP PLANS ENROLLMENT FORM

RESET FORM

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED.)

Employer name: _____ Employer number: _____

Employee last name: _____ First: _____ MI: _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

Birthdate: _____ Social Security number: _____

Telephone: _____ Email: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single Classification: _____

Monthly salary: _____ Date of Initial Eligibility: _____ Coverage effective date: _____

B. BENEFIT ELECTION

Term life Insurance

Employee life (employer base) ☐ Yes ☐ No

Amount*: $ _____

Employee optional life insurance ☐ Yes ☐ No

GI amount***: $ _____

UW amount**: $ _____

Spouse life insurance (employer base) ☐ Yes ☐ No

Spouse optional life insurance** ☐ Yes ☐ No

Child life insurance ☐ Yes ☐ No

*If employer base life salary multiple is greater than four, *Evidence of Good Health Application* is required.
**Requires *Evidence of Good Health Application*.
***Guaranteed Issue in flat amounts $10,000–$50,000 in $5,000 increments or multiple of salary up to $50,000.

Accidental Death & Dismemberment (AD&D) ☐ Yes ☐ No

Disability Plans

Short-term Disability ☐ Yes ☐ No Select one: Select One

Long-term Disability ☐ Yes ☐ No Select one: Select One

Supplemental AD&D

For myself ☐ Yes ☐ No Amount: $_____

For my spouse ☐ Yes ☐ No Amount: $_____ (50% of employee value)

If you are waiving Employer Paid Medical, Dental, and/or Vision, please complete Waiver on other side.

Medical Benefits

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): Select One

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.
[2]This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older. Participants in this plan could incur late enrollment penalties from Medicare.

Continued on other side

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Employee name: _____ Social Security number: _____

Dental Benefits

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): Select One

*Dental ID number required; please provide below.

Vision Benefits

For myself: ☐ Yes ☐ No For spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Coverage (select one): Select One

C. EMPLOYEE & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

An eligible spouse is a person of the opposite biological sex to whom you are legally married at the relevant time by civil or religious ceremony effective under the laws of the state in which the marriage was contracted. If an eligible spouse is over the age of 45 and does not have a social security number, an individual taxpayer identification number will be required for medical, dental, and/or vision enrollment. A copy of their ITIN assignment letter should accompany the enrollment form.

An eligible dependent child is a person under age 26 that is dependent on you or your spouse for support or maintenance and includes the following:

- Biological child
- Stepchild
- Foster child
- Child or grandchild for whom you or your spouse is the legal guardian or managing conservator
- Child whom you or your spouse must cover pursuant to a court or agency order or National Medical Support Notice under federal law
- Child 26 or over that is permanently incapacitated
- Adopted child/placed in home for adoption

Last name	First name	MI	Social Security Number	Birthdate	Relation-ship	Sex M/F	Medical Y/N	Dental Y/N	Dental ID Number†	Vision Y/N

* Your spouse and children under age 26 are eligible for coverage.
† Cigna Dental Care DHMO only.

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D. WAIVER OF MEDICAL, DENTAL, AND/OR VISION COVERAGE

For new Group Plans members: If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical, dental, and/or vision coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical, dental, and/or vision coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:	**I waive dental coverage for:**	**I waive vision coverage for:**
☐ Myself	☐ Myself	☐ Myself
☐ All eligible dependents	☐ All eligible dependents	☐ All eligible dependents
☐ Myself and all eligible dependents	☐ Myself and all eligible dependents	☐ Myself and all eligible dependents
☐ Only these dependents:	☐ Only these dependents:	☐ Only these dependents:

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

Name: _____ Social Security number (last four digits): _____

I understand that if I ask for coverage later, the terms of the plans will control my ability to get coverage. I also understand that waiting periods and other limitations may apply.

Special enrollees for medical coverage: Under federal law, if you decline enrollment for medical coverage for yourself or your dependents because of other medical (not dental) coverage, you may in the future be able to enroll yourself or your dependents as special enrollees in Group Plans. Also, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. To enroll as a special enrollee for medical coverage, you must request enrollment within 60 days after your other coverage ends or within 60 days after the marriage, birth, adoption or placement for adoption. These rules do not apply for dental coverage.

Note: Please see the plan booklets for information about waiting periods and other limitations for special enrollees.

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ **Date:** _____

Employer's Authorized Representative signature: _____ **Date:** _____

☐ I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s), and GuideStone may require reimbursement for claims paid on behalf of ineligible enrollees.

Email to your Groups Plan Support team or *Group.Insurance@GuideStone.org.***

***This is an unmonitored inbox for form submission ONLY.**

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